

Appendix 27
Estate Recovery Affidavit

Department of Health and Social Services
Division of Health
DOH 1113 (4/93)

State of Wisconsin

ESTATE RECOVERY PROGRAM
HEIR INFORMATION

NAME OF DECEASED RESIDENT: _____

SOCIAL SECURITY NO: _____

DATE OF DEATH: _____

AMOUNT IN PERSONAL ACCOUNT: _____

PERSONAL ACCOUNT CONVEYED TO:

(Name of Heir)

(Address of Heir)

AMOUNT CONVEYED: _____

DATE CONVEYED: _____

CONVEYED BY WHOM: _____
(Name)

(Position)

NURSING HOME:

(Name)

(Address)

Mail to:

Wisconsin Department of Health and Social Services
Bureau of Health Care Financing
Coordination of Benefits Unit
P.O. Box 309
Madison, WI 53701-0309